FIRSTCOMP
MARKEL® Insuring America's Small Business®

**CALIFORNIA**
**CORPORATE OFFICERS / DIRECTORS**
**WAIVER OF WORKERS' COMPENSATION COVERAGE**

Name Insured _____ Policy Number _____

Insurer Markel Insurance Company

Pursuant to California Labor Code section 3352(p), I hereby certify, under penalty of perjury, that I am an officer or director of the above-named insured, which is a quasi-public or private corporation, and that I own at least 15 percent (15%) of the issued and outstanding stock of the above-named insured corporation. As a qualifying officer or director, I elect to be excluded from the corporation's workers' compensation insurance policy with the above-referenced insurer. I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the corporation's insurer and it shall remain in effect until I provide the insurer with a written withdrawal of this waiver. I understand and agree that by signing this waiver, I will not be entitled to coverage under the insured's workers' compensation policy with the above-referenced insurer if an employment-related injury occurs.

_____ _____
PRINT OFFICER'S/DIRECTOR'S FULL NAME TITLE

_____ _____
OFFICER/DIRECTOR SIGNATURE DATE

ACCEPTED:

_____ _____
[Insurance Company] DATE

**NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon our receipt and acceptance of a signed and properly completed form. The person electing exclusion must sign this form. Company representatives may not sign on behalf of the individual. One exclusion per form. Submit additional forms if needed.**

**Submit forms to:** CAStateExclusion@markelcorp.com or fax to 877-338-2667

FIRST COMP
MARKEL® Insuring America's Small Business®

**CALIFORNIA**
**GENERAL PARTNERS AND LLC MANAGING MEMBERS**
**WAIVER OF WORKERS' COMPENSATION COVERAGE**

Name Insured _____ Policy Number _____

Insurer Markel Insurance Company

Pursuant to California Labor Code section 3352(q), I hereby certify, under penalty of perjury, that I am a general partner (if the insured is a partnership) or a managing member (if the insured is a limited liability company) of the above-named insured. As a qualifying general partner or managing member, I elect to be excluded from the insured's workers' compensation insurance policy with the above-referenced insurer. I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the partnership's or limited liability company's insurer and it shall remain in effect until I provide the insurer with a written withdrawal of this waiver. I understand and agree that by signing this waiver, I will not be entitled to coverage under the insured's workers' compensation insurance policy with the above-referenced insurer if an employment-related injury occurs.

_____ _____
PRINT GENERAL PARTNER'S/ MANAGING MEMBER'S FULL NAME | TITLE

_____ _____
GENERAL PARTNER / MANAGING MEMBER SIGNATURE | DATE

ACCEPTED:

_____ _____
[Insurance Company] | DATE

**NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon our receipt and acceptance of a signed and properly completed form. The person electing exclusion must sign this form. Company representatives may not sign on behalf of the individual. One exclusion per form. Submit additional forms if needed.**

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